MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
RADIATION CONTROL PROGRAM
UPDATED INFORMATION FOR RADIATION SOURCES

FACILITY NAME: _____

FACILITY ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE NUMBER: _____

RESPONSIBLE PERSON: _____

EMAIL ADDRESS: _____

CHECK OFF TYPE OF FACILITY USING CODES LISTED BELOW:

01- CHIROPRACTOR: ____
02- CLINIC: ____
03- DENTAL OFFICE: ____
04- EDUCATIONAL INSTITUTION: ____
05- HOSPITAL: ____
06- PHYSICIAN: ___
07- PODIATRIST: ___
08- PORTABLE: ___
09- RADIOLOGIST: ___
10- VETERINARIAN: ___
11- OTHER: ___

HOW MANY OF THE FOLLOWING MACHINES TYPES DO YOU HAVE?

MEDICAL:		**DENTAL:**	
Radiography	_____	*Intraoral*	_____
Fluoro	_____	*Nomad hand held*	_____
Portables	_____	*Panorex*	_____
C-Arms	_____	*Pan/Ceph Combo*	_____
CT	_____	*Ceph Unit*	_____
Bone Density	_____	*Cone beam CT*	_____

THERAPY: _____ **ANALYTICAL:** ____

SIGNATURE: _____ **DATE:** _____

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